STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #75516.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by:	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 The facility had a census of 64 residents. The sample included 14 residents. Based on observation, interview and record review the facility failed to notify the physician in a timely manner, for 1 sampled resident who had an accident, experienced swelling and pain, and a fractured left ankle. (#33) Of the 14 sampled residents, 5 were reviewed for unnecessary drug use. Based on interview, record review and observation the facility failed to report elevated blood pressures to the physician for 1 of 5 sampled residents. (#8) Findings included: - The (POS) Physician Order Sheet for Resident #33, dated 9/18/14, indicated diagnoses of a (CVA) Cerebrovascular Accident (stroke) with left sided hemiplegia (paralysis of one side of the body). The annual (MDS) Minimum Data Set assessment, dated 7/28/14, indicated the resident was cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15, required extensive assistance of 2 staff with bed mobility and transfers, and was independent with locomotion. The MDS indicated the resident's balance during surface to surface transfer was unsteady and he/she required assistance to balance, the resident had impaired (ROM) Range of Motion in 1 upper and 1 lower extremity. The MDS indicated the resident used a wheelchair for mobility, had no falls since the previous MDS, received (OT) Occupational Therapy and restorative range of motion exercises over 4 days of the look back period. The 7/28/14 (CAA) Care Area Assessment for	F 157		

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falls stated the resident had no falls this review period, was non-ambulatory and status post (CVA) Cerebrovascular Accident (stroke) with left sided hemiplegia. The summary indicated the staff used the sit to stand lift for all transfers and the resident was able to hold on with his/her right arm. The summary indicated the resident used an electric wheelchair for his/her primary mode of locomotion, and the staff encouraged the resident to wear nonskid footwear or socks at all times.

The 7/28/14 care plan for falls indicated the resident used an electric wheelchair for locomotion and directed the staff to use a sit to stand lift with 1 staff assistance during the day and 2 staff assistance at night for all transfers. The care plan lacked updates regarding the use of the manual wheelchair during periods when the electric wheelchair was not working. The care plan lacked instruction for the staff to ensure the resident's left leg (which had muscle weakness and hemiplegia) was appropriately secure during transport in the manual wheelchair.

The 8/1/14 at 12:41 PM, nurse's note indicated the resident's electric wheelchair was working, but not completely fixed and would sometimes quit working. The note further stated the resident was unable to wheel a manual wheelchair and did not like to have help.

The 8/10/14 at 4:34 PM nurse's note indicated at 4:00 PM, the staff pushed the resident, in his/her wheelchair, out into the hall while the resident positioned his/her left foot, over his/her right foot with no wheelchair foot pedals used. The note indicated the resident's left foot slipped off his/her right foot and was bent under the wheelchair. The note indicated the resident expressed pain and a nurse assessed the resident's ankle and found no

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swelling, redness or bruising at that time. The resident stated it was okay and independently propelled his/her wheelchair down the hall.

The 8/11/14 at 3:30 AM, nurse's note indicated the resident complained of pain in his/her left ankle and reported he/she bumped it on his/her wheelchair yesterday. The note indicated the staff noted the resident's left ankle was swollen and painful to touch when the staff barely touched the area. The note indicated the nurse administered Lortab (narcotic pain medication), as needed, to the resident and the staff applied an ice pack to the resident's left ankle. Review of the medical record revealed no documentation the staff reassessed the resident's ankle until approximately 11 hours later. Further review of the medical record revealed no documentation the staff notified the physician regarding the incident and the resident's increased pain or swollen left ankle.

The 8/11/14 at 4:00 PM, the physician's telephone order directed the staff to transport the resident to the hospital for an x-ray of his/her left ankle. (more than 23 hours after the accident and more than 12 hours after the staff noted the resident's left ankle was painful and swollen)

The 8/11/14 at 8:35 PM, nurse's note indicated the resident stated the pain in his/her left ankle had increased despite the ice packs the staff applied and he/she received Tylenol (pain relief medication), as needed. Review of the medical record revealed the resident received scheduled Lortab at bedtime. The note indicated the nurse notified the resident's family who agreed the resident's ankle should be x-rayed and the staff transported the resident to the hospital at 4:30 PM. The note stated the staff continued to apply

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ice packs, as needed, and Lortab as scheduled.

The 8/13/14 facility report stated the staff pushed the resident, in his/her wheelchair, into the hallway while the resident held up his/her flaccid (weak) left foot, with his/her right foot. The report indicated the resident's left foot slipped off his/her right foot, was caught on the carpet and bent under the wheelchair or bumped the wheelchair wheel.

On 10/14/14 at 10:50 AM, observation revealed the resident was in the beauty shop, in his/her electric wheelchair, his/her feet on a single full foot platform, with shoes on.

On 10/14/14 at 4:39 PM, observation revealed (CNA) Certified Nurse Aide K and L used a sit to stand lift to transfer the resident from his/her recliner to the toilet. Observation during the transfer revealed the resident's left arm hung down, limp and he/she used his/her right arm to hold on to the lift with both feet positioned forward on the lift platform. After the CNAs assisted the resident with toileting needs, they transferred the resident to his/her electric wheelchair and the resident independently propelled the wheelchair down the hall, at a slow to moderate speed, with both feet centered on the foot platform.

On 10/14/14 at 4:00 PM, (CMA) Certified Medication Aide M stated the resident always had both foot pedals on his/her wheelchair at all times, when being pushed by the staff. He/She stated the resident had left sided weakness, but was able to stand for transfers in the sit to stand lift.

On 10/16/14 at 8:44 AM, Administrative Nurse F stated the resident was able to report what

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happened when he/she hurt his/her ankle. The physician ordered a therapy evaluation, and the resident already received physical therapy, so the staff had not changed the care plan. He/She stated the accident happened on the evening shift, the resident did not complain of pain until the night shift and the physician and family were notified the next day. Administrative Nurse F verified the day shift nurse had not documented any assessment and the facility had no documentation the staff notified the physician until the following day at 4:00 PM, on the second shift. Administrative Nurse F stated the day shift nurse should have followed up and assessed the resident after he/she received a report that the resident received as needed pain medication and ice packs during the night for a painful, swollen ankle, and notified the physician. Administrative Nurse F verified the day shift nurse should have notified the physician of the accident and the resident's painful, swollen ankle. He/she stated the facility's fall policy was also used for accidents.

On 10/21/14 at 2:15 PM, Physician G stated he/she would expect the staff to notify him/her of an accident involving the resident, especially if there was an injury, and the staff should reassess the injury at the beginning of each shift Physician G stated he/she would expect the staff to use appropriate safety precautions when transporting the resident in any wheelchair.

The facility's 2007 fall policy directed the staff to notify the resident's family and physician of falls/accidents and update the care plan.

The facility's 3/15/13 policy for notification of the physician directed the staff to notify the physician by phone, when the resident had pain or

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deformity from a fall or accident.

The facility failed to notify Resident #33's physician, in a timely manner, after he/she had an accident, resulting in a swollen, painful ankle, and a resulting fracture.

- Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 9/29/14, indicated the resident scored 15 on the (BIMS) Brief Interview for Mental Status, which indicated intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities for Daily Living, ambulated with a walker, and was continent of bowel and bladder. The MDS indicated the resident received 7 days of an antidepressant medication.

The 4/30/14 (CAAs) Care Area Assessment summary for psychotropic drug use did not indicate any instructions for the monitoring and reporting of a resident's elevated blood pressure. The CAAs indicated the resident was a high risk for falls as he/she had frequent falls prior to admission to the facility and the resident's physician readjusted the resident's medications to prevent further falls prior to his/her admission.

The 9/29/14 care plan indicated the staff were to administer the resident's medications as ordered per physician's orders and to assess and record effectiveness of the drug treatment.

The 4/21/12 standing order for notifying the resident's physician for elevated blood pressures stated when the resident's (SBP) systolic blood pressure (top number) was above 170, or diastolic blood pressure (bottom number) was above 95, to recheck the resident's blood

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pressure in 15 minutes and then report the readings to the resident's physician.

The 9/29/14 physician's order, (initiated on 4/22/14) instructed the staff to obtain the resident's blood pressure twice a day and report if the systolic blood pressure was <100 and did not indicate the upper range.

The 4/22/14 physician's order instructed the staff to administer:
1) Coreg, (a high blood pressure medication), 25 (mg) milligrams, twice a day.
2) Cozaar (a high blood pressure medication), 50 mg, twice a day.

The 5/1/14 physician's order instructed the staff to administer Norvasc, (a high blood pressure medication), 5 mg, twice a day.

The 7/14/14 physician's progress notes indicated the resident had episodes of high blood pressure.

The 9/18/14 physicians's order instructed the staff to increase Norvasc, (a high blood pressure medication), to 5 mg, twice a day. The resident continues on the Coreg and the Cozaar.

Further review of the resident's medical record did not indicate specific individualized upper limits of the SBP to be reported to the resident's physician.

The 9/23/14 at 8:28 AM, nurse's notes indicated the resident's blood pressures were: lying 179/84, sitting 185/89, and standing 176/84. The nurses's note stated Norvasc, (a high blood pressure medication) was increased on 9/18/14 to 5mg, twice a day, due to the resident's elevated blood pressure.

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F 157	Continued From page 8 The resident's medical record revealed the resident's following blood pressures outside the standing order's for blood pressure notification: 10/14/14 at 9:20 AM 177/75 10/9/14 at 7:43 AM 182/80 10/8/14 at 7:25 AM 177/70 10/6/14 at 4:00 PM 172/89 10/5/14 at 1:05 PM 178/92 10/2/14 at 2:59 PM 179/88 10/2/14 at 7:08 AM 174/89 10/1/14 at 2:55 PM 172/83 10/1/14 at 9:47 AM 173/65 10/1/14 at 9:46 AM 187/90 9/29/14 at 3:16 PM 178/83 9/29/14 at 7:30 AM 186/76 9/26/14 at 10:53 AM 177/70 9/26/14 at 7:35 AM 188/76 9/25/14 at 2:59 PM 172/87 9/25/14 at 6:49 AM 186/81 9/24/14 at 7:57 AM 178/85 9/23/14 at 7:11 AM 174/84 9/21/14 at 7:17 AM 180/84 9/17/14 at 3:42 PM 172/84 9/16/14 at 9:45 AM 186/86 9/16/14 at 7:00 AM 203/87 9/14/14 at 3:52 PM 181/59 9/12/14 at 7:28 AM 189/89 9/11/13 at 6:50 AM 200/80 9/9/14 at 7:03 AM 176/88 9/8/14 at 6:38 AM 181/85 9/7/14 at 7:26 AM 172/77 9/6/14 at 7:40 AM 173/77 9/5/14 at 9:07 AM 172/83 9/4/14 at 4:07 PM 190/76 9/3/14- at 7:05 AM 188/90 9/2/14- at 7:17 AM 183/83 Further review of the resident's medical record	F 157		

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revealed no staff follow up documentation after the resident had elevated blood pressures, on 33 occasions, and no physician notification of the resident's elevated blood pressures.

On 10/14/14 at 11:03 AM, observation revealed the well groomed resident, resting in a recliner, in his/her room, reading e-mails on a touch pad.

On 10/16/14 at 7:25 AM, Nurse Aide D stated the nurses or the medication aides take the resident's blood pressures.

On 10/16/14 at 8:45 AM, Nurse E stated the nurses take the resident's blood pressures verified the resident's blood pressure parameters of 90-170/40-95 per standing order. Nurse E verified the resident had several blood pressures, outside of the standing order range, (indicated in red in the vital sign record.

On 10/16/14 at 9:00 AM, Administrative Nurse F stated the nurses are to report, to the resident's physician, blood pressures outside standing order parameters or specific parameters set by his/her physician, and staff were to document the physician notification. Administrative Nurse F Joyce stated the nurses usually take the resident's blood pressure in the morning before administering the resident's blood pressure medications and the nurses were to recheck the resident's blood pressure again in 15 minutes if it was elevated and document the reading in the resident's nurse's notes. Administrative Nurse F verified the staff had not notified the resident's physician regarding the elevated blood pressures.

On 10/16/14 at 10:30 AM, Physician G stated he/she expected the nurses to notify him/her if the resident's blood pressures were elevated.

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F 157	Continued From page 10 He/she stated it as difficult to change the morbidity (the incidence of disease) or mortality (the state of being subject to death) of residents in the nursing homes, but blood pressure were one of them. The facility failed to report Resident # 8's elevated blood pressures, to his/her physician, while he/she received multiple blood pressure medications.	F 157		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 14 residents of which 4 were reviewed for accidents. Based on observation, interview and record review the facility failed to provide care and services to prevent injuries during transport with a wheelchair, which resulted in a fracture, for 1 of 4 residents reviewed for accidents. (#33) Based on observation, record review and interview the facility failed to adequately monitor the water temperature on 1 of 4 halls to ensure the hot water temperature was within safe, acceptable ranges for the residents residing on the hall.	F 323		

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F 323	Continued From page 11 Findings included: - The (POS) Physician Order Sheet for Resident #33, dated 9/18/14, indicated diagnoses of a (CVA) Cerebrovascular Accident (stroke) with left sided hemiplegia (paralysis of one side of the body). The annual (MDS) Minimum Data Set assessment, dated 7/28/14, indicated the resident cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15, required extensive assistance of 2 staff with bed mobility and transfers, and was independent with locomotion. The MDS indicated the resident's balance during surface to surface transfer was unsteady and he/she required assistance to balance, the resident had impaired (ROM) Range of Motion in 1 upper and 1 lower extremity. The MDS indicated the resident used a wheelchair for mobility, had no falls since the previous MDS, received (OT) Occupational Therapy and restorative range of motion exercises over 4 days of the look back period. The 7/28/14 (CAA) Care Area Assessment for falls stated the resident had no falls this review period, was non-ambulatory and status post CVA with left sided hemiplegia. The summary indicated the staff used the sit to stand lift for all transfers and the resident was able to hold on with his/her right arm. The summary indicated the resident used an electric wheelchair for his/her primary mode of locomotion, and the staff encouraged the resident to wear nonskid footwear or socks at all times. The 7/28/14 care plan for falls indicated the resident used an electric wheelchair for	F 323		

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locomotion and directed the staff to use a sit to stand lift with 1 staff assistance during the day and 2 staff assistance at night for all transfers. The care plan lacked updates regarding the use of the manual wheelchair during periods when the electric wheelchair was not working. The care plan lacked instruction for the staff to ensure the resident's left leg (which had muscle weakness and hemiplegia) was appropriately secure during transport in the manual wheelchair.

The 8/1/14 at 12:41 PM, nurse's note indicated the resident's electric wheelchair was working, but not completely fixed and would sometimes quit working. The note further stated the resident was unable to wheel a manual wheelchair and did not like to have help.

The 8/10/14 at 4:34 PM nurse's note indicated at 4:00 PM, the staff pushed the resident, in his/her manual wheelchair, out into the hall while the resident positioned his/her weak left foot (affected by hemiplegia) over his/her right foot, with no wheelchair foot pedals in place. The note indicated the resident's left foot slipped off his/her right foot and was bent under the wheelchair. The note indicated the resident expressed pain and a nurse assessed the resident's ankle and found no swelling, redness or bruising at that time. The resident stated it was okay and independently propelled his/her wheelchair down the hall.

The 8/11/14 at 3:30 AM, nurse's note indicated the resident complained of pain in his/her left ankle and reported he/she bumped it on his/her wheelchair yesterday. The note indicated the staff noted the resident's left ankle was swollen and painful to touch when the staff barely touched the area. The note indicated the nurse administered Lortab (narcotic pain medication), as needed, to

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the resident and the staff applied an ice pack to the resident's left ankle. Review of the medical record revealed no documentation the staff reassessed the resident's ankle until approximately 11 later. Further review of the medical record revealed no documentation the staff notified the physician regarding the incident and the resident's increased pain or swollen left ankle.

The 8/11/14 at 4:00 PM, the physician's telephone order directed the staff to transport the resident to the hospital for an x-ray of his/her left ankle. (more than 23 hours after the accident and more than 12 hours after the staff noted the resident ' s left ankle was painful and swollen)

The 8/11/14 at 8:35 PM, nurse's note indicated the resident stated the pain in his/her left ankle had increased despite the ice packs the staff applied and he/she received Tylenol (pain relief medication), as needed. Review of the medical record revealed the resident received scheduled Lortab at bedtime. The note indicated the nurse notified the resident's family who agreed the resident's ankle should be x-rayed and the staff transported the resident to the hospital at 4:30 PM. The note stated the staff continued to apply ice packs, as needed, and Lortab as scheduled.

The 8/13/14 facility report stated the staff pushed the resident, in his/her wheelchair, into the hallway while the resident held up his/her weak left foot with his/her right foot. The report indicated the resident's left foot slipped off his/her right foot, was caught on the carpet and bent under the wheelchair or bumped the wheelchair wheel.

On 10/14/14 at 10:50 AM, observation revealed

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the resident was in the beauty shop, in his/her electric wheelchair, his/her feet on a single full foot platform, with shoes on.

On 10/14/14 at 4:39 PM, observation revealed Nurse Aide K and L used a sit to stand lift to transfer the resident from his/her recliner to the toilet. Observation during the transfer revealed the resident's left arm hung down, limp and he/she used his/her right arm to hold on to the lift with both feet positioned forward on the lift platform. After the CNAs assisted the resident with toileting needs, they transferred the resident to his/her electric wheelchair and the resident independently propelled the wheelchair down the hall, at a slow to moderate speed, with both feet centered on the foot platform.

On 10/14/14 at 4:00 PM, Nurse Aide M stated the resident always had both foot pedals on his/her wheelchair at all times, when being pushed by the staff. He/She stated the resident had left sided weakness, but was able to stand for transfers in the sit to stand lift.

On 10/16/14 at 8:44 AM, Administrative Nurse F stated the resident was able to report what happened when he/she hurt his/her ankle. He/she verified the staff had not changed the care plan either before the accident to reflect the use of the manual wheelchair, or after, to ensure the staff positioned the resident's feet appropriately when using the wheelchair. He/She stated the accident happened on the evening shift, the resident did not complain of pain until the night shift and the physician and family were notified the next day. Administrative Nurse F verified the day shift nurse had not documented any assessment and the facility had no documentation the staff notified the physician until the following day at 4:00 PM, on

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the second shift. Administrative Nurse F stated the day shift nurse should have followed up and assessed the resident after he/she received a report that the resident received as needed pain medication and ice packs during the night for a painful, swollen ankle. Administrative Nurse F verified the day shift nurse should have notified the physician of the accident and painful, swollen ankle. He/she stated the facility's fall policy was also used for accidents.

On 10/21/14 at 2:15 PM, Physician G stated he/she would expect the staff to notify him/her of an accident involving the resident, especially if there was an injury, and the staff should reassess the injury at the beginning of each shift Physician G stated he/she would expect the staff to use appropriate safety precautions when transporting the resident in any wheelchair.

The facility's 2007 fall policy directed the staff to notify the resident's family and physician of falls/accidents and update the care plan.

The facility failed to transport this dependent resident via wheelchair, in a safe manner, which resulted in a fracture of his/her left ankle/foot.
- On 10/14/14 at 8:38 AM, observation revealed the hot water in multiple resident bathrooms had visible steam and was too hot for this surveyor to place his/her hands under the faucet stream. The hot water temperatures were checked in the following rooms:
East 2 - 138.0 degrees
East 3 - 134.8 degrees
East 5 - 138.7 degrees
East 6 - 137.6 degrees
East 8 - 134.6 degrees
East 9 - 132.8 degrees
Therapy room on east hall - 133.8 degrees

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F 323	Continued From page 16 On 10/14/14 at 8:46 AM, the hot water temperatures in the residents' bathrooms were reported to the maintenance department and the staff turned off the hot water to the east hall. Review of the facility's Weekly Water Temperature Checklist form revealed no documentation the staff had checked the hot water temperatures on the east hall on the following days: 09/12/14 09/19/14 09/26/14 10/02/14 10/09/14 On 10/14/14 at 8:46 AM, Maintenance Staff A stated the maintenance staff had checked the hot water temperature weekly in random resident rooms and recorded the water temperature and room number on the facility's Weekly Water Temperature Checklist form. Maintenance Staff A also stated there was no documentation the staff had checked water temperatures on the east hall in the past month. On 10/15/14 at 10:30 AM, Nurse Aide B stated the hot water temperature had been elevated in the residents' bathrooms on the east hall for at least a week. Nurse Aide B also stated he/she was not aware if the hot water temperature had been reported to the maintenance department. On 10/15/14 at 10:45 AM, Housekeeping Staff C stated the hot water temperature had been elevated on the east hall for several days and he/she had not reported the unsafe hot water temperature to the nursing or maintenance staff.	F 323		

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F 323	Continued From page 17 On 10/15/14 at 11:02 AM, Administrative Staff H stated the staff should check the hot water temperature on each hall weekly and address immediately if unsafe water temperatures were noted. Administrative Staff H also stated the direct care staff should report elevated/unsafe hot water temperatures to administration or the maintenance staff. The facility failed to adequately monitor the water temperature on 1 hall to ensure the hot water temperature was within safe, acceptable ranges.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This Requirement is not met as evidenced by:
The facility had a census of 64 residents. The sample included 14 residents of which 5 were reviewed for unnecessary drug use. Based on interview, record review and observation the facility failed to monitor drug side effects for 2 of 5 sampled residents. The facility failed monitor and reassess Resident #8's elevated blood pressure and monitor Resident #7's bowel elimination in order to prompt assessment to determine needed interventions to prevent or ease constipation.

Findings included:

- Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 9/29/14, indicated the resident scored 15 on the (BIMS) Brief Interview for Mental Status, which indicated intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities for Daily Living, ambulated with a walker, and was continent of bowel and bladder. The MDS indicated the resident received 7 days of an antidepressant medication.

The 4/30/14 (CAAs) Care Area Assessment summary for psychotropic drug use did not indicate any instructions for the monitoring and reporting of a resident's elevated blood pressure. The CAAs indicated the resident was a high risk for falls as he/she had frequent falls prior to admission to the facility and the resident's physician readjusted the resident's medications to prevent further falls prior to his/her admission.

The 9/29/14 care plan indicated the staff were to administer the resident's medications as ordered per physician's orders and to assess and record

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F 329	Continued From page 19 effectiveness of the drug treatment. The 4/21/12 standing order for notifying the resident's physician for elevated blood pressures stated when the resident's (SBP) systolic blood pressure (top number) was above 170, or diastolic blood pressure (bottom number) was above 95, to recheck the resident's blood pressure in 15 minutes and then report the readings to the resident's physician. The 9/29/14 physician's order, (initiated on 4/22/14) instructed the staff to obtain the resident's blood pressure twice a day and report if the systolic blood pressure was <100 and did not indicate the upper range. The 4/22/14 physician's order instructed the staff to administer: 1) Coreg, (a high blood pressure medication), 25 (mg) milligrams, twice a day. 2) Cozaar (a high blood pressure medication), 50 mg, twice a day. The 5/1/14 physician's order instructed the staff to administer Norvasc, (a high pressure medication), 5 mg, daily. The 7/14/14 physician's progress notes indicated the resident had episodes of high blood pressure. The 9/18/14 physicians's order instructed the staff to increase Norvasc, to 5 mg, twice a day. The resident continues on the Coreg and the Cozaar. Further review of the resident's medical record did not indicate specific individualized upper limits of the SBP to be reported to the resident's physician.	F 329		

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F 329	Continued From page 20 The 9/23/14 at 8:28 AM, nurse's notes indicated the resident's blood pressures were: lying 179/84, sitting 185/89, and standing 176/84. The nurses's note stated Norvasc, (a high blood pressure medication) was increased on 9/18/14 to 5mg, twice a day, due to the resident's elevated blood pressure. The resident's medical record revealed the resident's following blood pressures outside the standing order's for blood pressure notification: 10/14/14 at 9:20 AM 177/75 10/9/14 at 7:43 AM 182/80 10/8/14 at 7:25 AM 177/70 10/6/14 at 4:00 PM 172/89 10/5/14 at 1:05 PM 178/92 10/2/14 at 2:59 PM 179/88 10/2/14 at 7:08 AM 174/89 10/1/14 at 2:55 PM 172/83 10/1/14 at 9:47 AM 173/65 10/1/14 at 9:46 AM 187/90 9/29/14 at 3:16 PM 178/83 9/29/14 at 7:30 AM 186/76 9/26/14 at 10:53 AM 177/70 9/26/14 at 7:35 AM 188/76 9/25/14 at 2:59 PM 172/87 9/25/14 at 6:49 AM 186/81 9/24/14 at 7:57 AM 178/85 9/23/14 at 7:11 AM 174/84 9/21/14 at 7:17 AM 180/84 9/17/14 at 3:42 PM 172/84 9/16/14 at 9:45 AM 186/86 9/16/14 at 7:00 AM 203/87 9/14/14 at 3:52 PM 181/59 9/12/14 at 7:28 AM 189/89 9/11/13 at 6:50 AM 200/80 9/9/14 at 7:03 AM 176/88 9/8/14 at 6:38 AM 181/85 9/7/14 at 7:26 AM 172/77	F 329		

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F 329	Continued From page 21 9/6/14 at 7:40 AM 173/77 9/5/14 at 9:07 AM 172/83 9/4/14 at 4:07 PM 190/76 9/3/14- at 7:05 AM 188/90 9/2/14- at 7:17 AM 183/83 Further review of the resident's medical record revealed no staff follow up documentation after the resident had elevated blood pressures, on 33 occasions, and no physician notification of the resident's elevated blood pressures. On 10/14/14 at 11:03 AM, observation revealed the well groomed resident, resting in a recliner, in his/her room, reading e-mails on a touch pad. On 10/16/14 at 7:25 AM, Nurse Aide D stated the nurses or the medication aides take the resident's blood pressures. On 10/16/14 at 8:45 AM, Nurse E stated the nurses take the resident's blood pressures verified the resident's blood pressure parameters of 90-170/40-95 per standing order. Nurse E verified the resident had several blood pressures, outside of the standing order range, (indicated in red in the vital sign record). On 10/16/14 at 9:00 AM, Administrative Nurse F stated the nurses are to report, to the resident's physician, blood pressures outside the standing order parameters or specific parameter set by his/her physician, and staff were to document the physician's notification. Administrative Nurse F stated the nurses usually take the resident's blood pressure in the morning before administering the resident's blood pressure medications and the nurses were to recheck the resident's blood pressure again in 15 minutes if it was elevated and document the reading in the	F 329		

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resident's nurse's notes. Administrative Nurse F verified the resident had several elevated blood pressures with no documentation of the blood pressure being repeated or the physician notification.

On 10/16/14 at 10:30 AM, Physician G stated he/she expected the nurses to notify him/her if the resident's blood pressures were elevated. He/she stated it was difficult to change the morbidity (the incidence of disease) or mortality (the state of being subject to death) of residents in the nursing homes, but blood pressure were one of them.

The facility failed to adequately monitor and reaccess Resident # 8, who received blood pressure medication and had numerous elevated blood pressures.

- Resident #7's quarterly (MDS) Minimum Data Set assessment, dated 9/2/14, indicated a (BIMS) Brief Interview for Mental Status score of 11, moderately impaired cognition, required limited staff assistance with eating, extensive assistance with all other (ADLs) Activities of Daily Living, and was always continent of bowel.

The 6/9/14 quarterly MDS indicated the same.

The significant change MDS, dated 3/17/14, indicated the resident had short/long term memory problems and moderately impaired decision making skill. The MDS indicated the resident required limited staff assistance with eating and extensive assistance with all other ADLs. The MDS indicated the resident was frequently incontinent of bowel and had no

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F 329	Continued From page 23 constipation. The 3/17/14 (CAA) Care Area Assessment summary for bowel/bladder indicated the resident frequently incontinent of bladder/bowel and required extensive assistance of 2 staff with toileting needs. The 9/2/14 care plan directed the staff to administer medications as scheduled, monitor the resident's response to medications, document the frequency and character of bowel movements and offer non-pharmacological bowel stimulants such as warm water drinks upon rising, and fruit juice. The care plan lacked time frames to direct the staff when to provide bowel stimulants or interventions. The 7/3/14 physician's orders directed the staff to administer Colace (mild laxative) 100 (mg) milligrams, twice daily, (initiated on 1/22/14), (MOM) Milk of Magnesia (laxative), 30 (cc) cubic centimeters, as needed, daily, (initiated on 6/17/09), and Miralax (laxative), 17 grams, as needed, daily, (initiated on 1/5/10). Review of the resident ' s bowel elimination reports revealed: No (BM) Bowel Movement 8/9-8/14 (6 consecutive days) No BM 9/3-9/14 (12 consecutive days) No BM 10/3-10/7 (5 consecutive days) Review of the nurse's notes 8/1/14 through 10/15/14 revealed no nursing assessment of the resident ' s bowel sounds or documentation of administration of interventions for the lack of bowel movements and no documentation the resident refused any bowel interventions to	F 329		

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prevent or ease constipation.

The 9/4/14 and 10/9/14 pharmacist consultant reviews of the resident's medication regimen indicated no recommendations regarding the bowel elimination management.

On 10/15/14 at 7:33 AM, observation revealed the resident in a recliner in his/her room.

On 10/16/14 at 7:55 AM, Nurse Aide N stated the resident required the assistance of 2 staff with toileting, and the staff documented the resident's BM on the electronic record. He/she stated nurses track the BMs via the electronic record and the aides cannot view the charting to determine when the staff documented the resident's last BM.

On 10/16/14 at 8:00 AM, Nurse O stated the aides document BMs in the electronic chart and the electronic record sends the nurse a resident message if no BMs are documented for 3 days. The nurse looks at the BM record and asks the resident, if possible, if they had a BM and then offer a laxative, as needed. He/she stated the nurse assessed the resident ' s bowel sounds if the resident was cognitively impaired. Nurse O stated, at times Resident #7 had been on the list of residents without a BM for 3 days and Nurse O stated he/she asked the resident if he/she wanted a (PRN) as needed laxative, but sometimes the resident refused. He/she stated nurses are to document bowel sounds and PRN medication interventions and verified the record had no documentation of bowel sound assessments, offers of PRN bowel interventions, or indications the resident refused any interventions.

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F 329	Continued From page 25 On 10/16/14 at 8:35 AM, Administrative Nurse F stated the resident was alert and oriented and able to let staff know if he/she was constipated. He/She stated the facility did not have a bowel monitoring policy. Administrative Nurse F verified the staff had not documented any PRN bowel interventions for the 3 periods in which the bowel elimination documentation lacked report of any BM for greater than 5 days. He/she verified the care plan and the routine physician orders lacked time frames to direct the staff when to provide bowel stimulants or interventions. The facility failed to monitor Resident #7's bowel elimination in order to prompt assessment to determine needed interventions to prevent or ease constipation.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to provide an air gap in the drainage system of an ice machine and prepare foods under sanitary conditions for the 64 residents, who reside in the facility and receive food and	F 371		

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F 371	Continued From page 26 fluids from the kitchen. Findings included: - On 10/13/14 at 9:40 AM, observation revealed the ice machine drainage system emptied directly into a floor drain with no air gap or anti-backflow valve to prevent backflow contamination. On 10/13/14 at 9:40 AM, Maintenance Staff A verified the ice machine had no air gap or anti-back flow valve in the drainage system to prevent backflow contamination. On 10/15/14 at 9:33 AM, observation during the kitchen/food service inspection, revealed the following findings: 1) 2 air vents, above the food preparation area, with fuzzy, gray lint and dust hanging from the vents 2) 1 circulation fan in the food preparation area with fuzzy, gray lint and dust on the fan blades 3) 2 ceiling fans with fuzzy, gray lint and dust hanging from the fan blades 4) an 8 inch by 4 inch hole in the block wall under the food preparation sink 5) 4 light fixtures with dust and lint on the outside covers On 10/16/14 at 9:00 AM, Dietary Staff P verified the fans, air vents and light fixtures needed cleaning. Dietary Staff P also verified the kitchen cleaning schedule had no documentation the air vents and fans were cleaned after 05/07/14. The undated facility Cook Weekly Cleaning Schedule directed the staff to clean the circulating and ceiling fans. Continued review of the cleaning schedule revealed no documentation to direct the staff to clean air vents and light fixtures.	F 371		

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F 371	Continued From page 27 The facility's 03/24/2000 Dietary Department Sanitation/Infection Control Procedure directed the staff to routinely clean non-food surfaces and fans to ensure a clean and sanitary environment. The facility failed provide an air gap in the drainage system of an ice machine and prepare foods under sanitary conditions for the 64 residents, who reside in the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 14 residents of which 5 were reviewed for unnecessary drug use. Based on interview, record review and observation the pharmacy consultant failed to identify and report drug irregularities to the resident's physician or the director of nursing, for 2 of 5 sampled residents, in regards to adequately monitoring Resident #8's blood pressure and Resident #7's bowel management program to prevent constipation. Findings included:	F 428		

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- Resident #8's quarterly (MDS) Minimum Data Set assessment, dated 9/29/14, indicated the resident scored 15 on the (BIMS) Brief Interview for Mental Status, which indicated intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities for Daily Living, ambulated with a walker, and was continent of bowel and bladder. The MDS indicated the resident received 7 days of an antidepressant medication.

The 4/30/14 (CAAs) Care Area Assessment summary for psychotropic drug use did not indicate any instructions for the monitoring and reporting of a resident's elevated blood pressure. The CAAs indicated the resident was a high risk for falls as he/she had frequent falls prior to admission to the facility and the resident's physician readjusted the resident's medications to prevent further falls prior to his/her admission.

The 9/29/14 care plan indicated the staff were to administer the resident's medications as ordered per physician's orders and to assess and record effectiveness of the drug treatment.

The 4/21/12 standing order for notifying the resident's physician for elevated blood pressures stated when the resident's (SBP) systolic blood pressure (top number) was above 170, or diastolic blood pressure (bottom number) was above 95, to recheck the resident's blood pressure in 15 minutes and then report the readings to the resident's physician.

The 9/29/14 physician's order, (initiated on 4/22/14) instructed the staff to obtain the resident's blood pressure twice a day and report if the SBP systolic blood pressure was <100 and

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F 428	Continued From page 29 did not indicate the upper range. The 4/22/14 physician's order instructed the staff to administer: 1) Coreg, (a high blood pressure medication), 25 (mg) milligrams, twice a day. 2) Cozaar (a high blood pressure medication), 50 mg, twice a day. The 5/1/14 physician's order instructed the staff to administer Norvasc, (a high blood pressure medication), 5 mg, daily. The 7/14/14 physician's progress notes indicated the resident had episodes of high blood pressure. The 9/18/14 physicians's order instructed the staff to increase Norvasc, (a high blood pressure medication), to 5 mg, twice a day. The resident continues on the Coreg and the Cozaar. Further review of the resident's medical record did not indicate specific individualized upper limits of the SBP to be reported to the resident's physician. The 9/23/14 at 8:28 AM, nurse's notes indicated the resident's blood pressures were: lying 179/84, sitting 185/89, and standing 176/84. The nurses's note stated Norvasc, (a high blood pressure medication) was increased on 9/18/14 to 5mg, twice a day, due to the resident's elevated blood pressure. The resident's medical record revealed the resident's following blood pressures outside the standing order's for blood pressure notification: 10/14/14 at 9:20 AM 177/75 10/9/14 at 7:43 AM 182/80	F 428		

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F 428	Continued From page 30 10/8/14 at 7:25 AM 177/70 10/6/14 at 4:00 PM 172/89 10/5/14 at 1:05 PM 178/92 10/2/14 at 2:59 PM 179/88 10/2/14 at 7:08 AM 174/89 10/1/14 at 2:55 PM 172/83 10/1/14 at 9:47 AM 173/65 10/1/14 at 9:46 AM 187/90 9/29/14 at 3:16 PM 178/83 9/29/14 at 7:30 AM 186/76 9/26/14 at 10:53 AM 177/70 9/26/14 at 7:35 AM 188/76 9/25/14 at 2:59 PM 172/87 9/25/14 at 6:49 AM 186/81 9/24/14 at 7:57 AM 178/85 9/23/14 at 7:11 AM 174/84 9/21/14 at 7:17 AM 180/84 9/17/14 at 3:42 PM 172/84 9/16/14 at 9:45 AM 186/86 9/16/14 at 7:00 AM 203/87 9/14/14 at 3:52 PM 181/59 9/12/14 at 7:28 AM 189/89 9/11/13 at 6:50 AM 200/80 9/9/14 at 7:03 AM 176/88 9/8/14 at 6:38 AM 181/85 9/7/14 at 7:26 AM 172/77 9/6/14 at 7:40 AM 173/77 9/5/14 at 9:07 AM 172/83 9/4/14 at 4:07 PM 190/76 9/3/14- at 7:05 AM 188/90 9/2/14- at 7:17 AM 183/83 Further review of the resident's medical record revealed no staff follow up documentation after the resident had elevated blood pressures, on 33 occasions, and no physician notification of the resident's elevated blood pressures. Review of the pharmacist consultant review on 6/5/14, 7/10/14, 8/7/14, 9/4/14, 10/8/14 revealed	F 428		

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F 428	Continued From page 31 the pharmacist consultant had made no recommendations. On 10/14/14 at 11:03 AM, observation revealed the well groomed resident, resting in a recliner, in his/her room, reading e-mails on a touch pad. On 10/16/14 at 7:25 AM, Nurse Aide D stated the nurses or the medication aides take the resident's blood pressures. On 10/16/14 at 8:45 AM, Nurse E stated the nurses take the resident's blood pressures verified the resident's blood pressure parameters of 90-170/40-95 per standing orders. Nurse E verified the resident had several blood pressures outside of the standing order range, (indicated in red in the vital sign record). On 10/16/14 at 9:00 AM, Administrative Nurse F stated the nurses are to report, to the resident's physician, blood pressures outside standing order parameters or specific parameters set by his/her physician, and staff were to document the physicians notification. Administrative Nurse F stated the nurses usually take the resident's blood pressure in the morning before administering the resident's blood pressure medications and the nurses were to recheck the resident's blood pressure again in 15 minutes if it was elevated and document the reading in the resident's nurse's notes. Administrative Nurse F verified the resident had several elevated blood pressures with no documentation of the blood pressure being repeated or the physician notification. Administrative Nurse F stated the pharmacy consultant had not identified or addressed the elevated blood pressures outside of standing order parameters with the director of nursing or the resident's physician.	F 428		

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F 428	Continued From page 32 On 10/16/14 at 10:30 AM, Physician G stated he/she expected the nurses to notify him/her if the resident's blood pressures were elevated. He/she stated it was difficult to change the morbidity (the incidence of disease) or mortality (the state of being subject to death) of residents in the nursing homes, but blood pressure. The facility's pharmacy consultant failed to report drug irregularities to the resident's physician or the director of nursing, regarding Resident # 8's elevated blood pressure, while he/she received multiple blood pressure medications. - Resident #7's quarterly (MDS) Minimum Data Set assessment, dated 9/2/14, indicated a (BIMS) Brief Interview for Mental Status score of 11, moderately impaired cognition, required limited staff assistance with eating, extensive assistance with all other (ADLs) Activities of Daily Living, and was always continent of bowel. The 6/9/14 quarterly MDS indicated the same. The significant change MDS, dated 3/17/14, indicated the resident had short/long term memory problems and moderately impaired decision making skill. The MDS indicated the resident required limited staff assistance with eating and extensive assistance with all other ADLs. The MDS indicated the resident was frequently incontinent of bowel and had no constipation. The 3/17/14 (CAA) Care Area Assessment	F 428		

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summary for bowel/bladder indicated the resident frequently incontinent of bladder/bowel and required extensive assistance of 2 staff with toileting needs.

The 9/2/14 care plan directed the staff to administer medications as scheduled, monitor the resident's response to medications, document the frequency and character of bowel movements and offer non-pharmacological bowel stimulants such as warm water drinks upon rising, and fruit juice. The care plan lacked time frames to direct the staff when to provide bowel stimulants or interventions.

The 7/3/14 physician's orders directed the staff to administer Colace (mild laxative) 100 (mg) milligrams, twice daily, (initiated on 1/22/14), (MOM) Milk of Magnesia (laxative), 30 (cc) cubic centimeters, as needed, daily, (initiated on 6/17/09), and Miralax (laxative), 17 grams, as needed, daily, (initiated on 1/5/10).

Review of the resident ' s bowel elimination reports revealed:
No (BM) Bowel Movement 8/9-8/14 (6 consecutive days)
No BM 9/3-9/14 (12 consecutive days)
No BM 10/3-10/7 (5 consecutive days)

Review of the nurse's notes 8/1/14 through 10/15/14 revealed no nursing assessment of the resident ' s bowel sounds or documentation of administration of interventions for the lack of bowel movements and no documentation the resident refused any bowel interventions to prevent or ease constipation.

The 9/4/14 and 10/9/14 pharmacist consultant reviews of the resident's medication regimen

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F 428	Continued From page 34 indicated no recommendations regarding the bowel elimination management. On 10/15/14 at 7:33 AM, observation revealed the resident in a recliner in his/her room. On 10/16/14 at 7:55 AM, Nurse Aide N stated the resident required the assistance of 2 staff with toileting, and the staff documented the resident's BM on the electronic record. He/she stated nurses track the BMs via the electronic record and the aides cannot view the charting to determine when the staff documented the resident's last BM. On 10/16/14 at 8:00 AM, Nurse O stated the aides document BMs in the electronic chart and the electronic record sends the nurse a resident message if no BMs are documented for 3 days. The nurse looks at the BM record and asks the resident, if possible, if they had a BM and then offer a laxative, as needed. He/she stated the nurse assessed the resident ' s bowel sounds if the resident was cognitively impaired. Nurse O stated, at times Resident #7 had been on the list of residents without a BM for 3 days and Nurse O stated he/she asked the resident if he/she wanted a (PRN) as needed laxative, but sometimes the resident refused. He/she stated nurses are to document bowel sounds and PRN medication interventions and verified the record had no documentation of bowel sound assessments, offers of PRN bowel interventions, or indications the resident refused any interventions. On 10/16/14 at 8:35 AM, Administrative Nurse F stated the resident was alert and oriented and able to let staff know if he/she was constipated.	F 428		

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F 428	Continued From page 35 He/She stated the facility did not have a bowel monitoring policy. Administrative Nurse F verified the staff had not documented any PRN bowel interventions for the 3 periods in which the bowel elimination documentation lacked report of any BM for greater than 5 days. He/she verified the care plan and the routine physician orders lacked time frames to direct the staff when to provide bowel stimulants or interventions. The facility's consultant pharmacist failed to report, to the Director of Nursing, the lack of bowel elimination interventions, as indicated, for the periods of greater than 5 consecutive days without bowel elimination for Resident #7.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 36 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 14 residents. Based on interview, record review and interview the facility failed to ensure the staff allowed the disinfectant, used by housekeeping staff to clean the residents' rooms, remained wet on surfaces for a minimum of 10 minutes. Findings included: - On 10/16/14 at 7:30 AM, observation revealed Housekeeping Staff I cleaning a resident's room using, Betco pH7P Ultra One Step Disinfectant Germicidal Detergent Deodorant, to disinfectant the resident's sink, outside of the toilet, walls, doors, and door knobs. Immediately after wiping the disinfectant solution on the plumbing behind the toilet, under the sink, hall/towel bars and the two gray steel shelves above the (BR) bathroom counter, Housekeeper Staff I dried these items with paper towels. Housekeeping Staff I stated	F 441		

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F 441	Continued From page 37 he/she dried the plumbing and other gray steel items with a paper towel right away and then applied a small amount of baby oil, with a paper towel, to help prevent rust. The 2013 Betco pH7Q Ultra One Step Disinfectant Germicidal Detergent Deodorant manufacturer's instructions instructed to let the solution remain on the surface for a minimum of 10 minutes and to make sure to wet all surfaces completely and let air dry. On 10/16/14 at 8:30 AM, Housekeeping Staff J stated the housekeepers are to dry the items they clean with the disinfectant solution with a paper towel and then to spray Steriphene, (disinfectant deodorant) on the cleaned items and let air dry. The facility failed to maintain a safe and sanitary environment to help prevent the development and transmission of diseases by housekeeping when cleaning the resident's rooms.	F 441		